

Federal Health Funding to First Nations in the Territories

A Discussion Document

Draft

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Executive Summary

First Nation communities in the NWT and Yukon are subject to different practices regarding the funding and provision of federal health programs compared to their provincial counterparts. These differences are founded in the past role of the federal government in providing health services to the territorial populations and the mechanisms used to transfer these health services to the territorial governments, legal designations of First Nations land, dissimilar funding mechanisms to First Nations in the territories versus provinces, and the federal policy framework for northern health funding. Taken together, these various realities have contributed to the present situation whereby federal funding for certain health programs to First Nations communities in the territories may be provided at a lower level when compared against First Nations communities in the provinces, or in some cases, may not be provided at all.

Currently, Health Canada policy regarding the funding of health programs to First Nations in the territories includes a provision that new First Nations and Inuit Health Branch (FNIHB) programs which duplicate responsibility in areas transferred to the territorial governments and funded through the Canada Health Act (CHA) and Territorial Formula Financing (TFF) Agreement, should not be funded. This provision is meant to prevent double dipping, or the receipt of funds for similar health services from both federal and territorial coffers, and has been challenged by First Nations; for example, Yukon First Nations assert that they do not receive comparable funding from the Yukon Government (YG) for the delivery of programs and services otherwise meant to be provided through federal enhancements, nor do they receive territorial services in their communities which are comparable.

In recent years, FNIHB has embraced the term “First Nations on reserve and Inuit communities” to describe the eligible population for many of its programs. This combined, with the policy that health treatment and dental prevention services are not to be funded because of perceived double dipping¹ has resulted in territorial First Nations being excluded from the following FNIHB programs and enhancements: treatment component of the Maternal and Child Health (MCH) Program, E Health solutions, pandemic influenza planning, primary health care portion of any federal investments, Children’s Oral Health Initiative (COHI), environmental health research and health contaminants programs, and West Nile virus funding. As well, territorial First Nations cannot access the federal government’s funding to First Nations under the Early Learning and Child Care Initiative. In the NWT, First Nations cannot directly access reinvestment funds from the First Nations portion of the National Child Benefit Initiative. Instead, these funds are directed to the GNWT for administration.

The eligible population described as First Nations on reserve for new or enhanced FNIHB programs has added significance given the federal interpretation of self-government agreements (SGAs). All Yukon First Nations SGAs contain a clause which states that the agreement will not

¹ Existing treatment and dental prevention services were included in the federal health transfer agreements with the YG and the Government of the Northwest Territories (GNWT). The federal policy is to prevent duplication of funding in areas which have been transferred to territorial jurisdiction.

affect the ability of citizens to participate in and benefit from Government programs for status Indians, non-status Indians or native people, as the case may be. The clause has been interpreted by some federal officials as relating only to Aboriginal programs of general application, not those described as for First Nations on reserve. It should be noted that neither land claim agreements nor SGAs contain a clause requiring the federal government to notify self-governing First Nations about new program opportunities.

The federal-territorial health transfer agreements have limited the eligibility of First Nations for certain federal programs, for example, health treatment and preventative dental care. The MCH Program is an example of a territorial First Nations exclusion based on the inclusion of treatment services in the health transfer agreements. Although at the time of the NWT and Yukon transfers, treatment in community services generally meant nursing and physician services, it has now been applied much more broadly, as in the case of the MCH Program, to lay people who provide home visitor mentoring services.² These MCH services will not be funded to territorial First Nations.

COHI provides another example of the application of federal-territorial transfer agreements. At the time of the federal health transfer to the territories, federal programs were often minimal. Preventative dental services were school-based. However, the federal government's position is that the school services were representative of a dental prevention program which was transferred and therefore any further expansion in this area is the responsibility of the territorial government, and not COHI. The GNWT maintains that they received only a school-based program and have no commitment to a larger dental prevention program to First Nations. That this federal decision on non-eligibility could be counter productive to FNIHB's financial bottom line given the significantly poor dental health of children in the north was only considered after advocacy by the Northern Secretariat of FNIHB. Eligibility for COHI's first year pilot funding was extended late to Inuit in Nunavut – a population where \$2 million in federal funds was recently spent on hospital-based extractions to children as young as five years of age. First Nations in the territories who also have high emergency extraction rates in children are currently non-eligible for COHI; however, a broader eligibility in the territories which will include First Nations is now being considered.

Territorial First Nations may receive lesser or inadequate health program funding even for those areas they are deemed to be eligible. The issues surrounding program allocation formulae are complex and will be considered in a separate document. However, the result of funding policies can be an extremely low amount of resources being provided to First Nations in the territories. For example, in the first year of the MCH program, Yukon First Nations qualify for \$55,000 (non-treatment component). This amount is to be spread among all fourteen First Nations. Future options are limited for First Nations who are subject to inadequate resources – either health

² Lay visitors are an integral part of the MCH Program for First Nations communities in the provinces.

programs will be limited or unrecognized contributions to ensuring program sustainability will be required from limited own source revenues.³

As another example, the Non-Insured Health Benefits (NIHB) Program which is vitally important to ensuring access to needed pharmacy, dental and vision benefits, and transport to medically necessary services, is a status only program. At this time, 30% of self-governing Yukon First Nations are not eligible for these benefits. In the NWT, First Nations have little involvement in the management of these benefits as they are administered by the GNWT and have been merged with the GNWT funded benefits directed to the non-First Nations and Inuit population. From the First Nations perspective, there is no demonstrated accountability or transparency in how federal dollars are spent, in particular if all of these resources are spent on First Nations or if there is partial subsidization of services to non-First Nations.

The ability of First Nations to successfully bring attention to perceived inequities and achieve change is a function of their credibility in matters of governance, knowledge of health services and involvement in the health system. First Nations, even those who are self-governing, face challenges in being recognized as equal partners in discussions on health services, not merely as stakeholders who must be consulted prior to government making unilateral decisions on services. In the NWT, First Nations capacity in health service delivery is lacking due to the existing agreements between the federal and territorial governments which has meant that the GNWT, not First Nations, administers federal health programs. This observation can also apply to Yukon First Nations in some program areas.

In summary, Health Canada's restrictions regarding eligibility of territorial First Nations for new and enhanced programs are based on three main concepts: (1) non funding of programs considered to have been transferred to the territorial governments, (2) the use of "First Nations on reserve" to describe new program eligibility, and (3) the interpretation of SGA clauses protecting First Nations access to new federal programs as only applying to general Aboriginal programs. Health Canada financing of self-governing Yukon First Nations is based on status-only population numbers and excludes all other non-status residents in communities (which are estimated to be 30% of residents). In addition, the funding allocation mechanisms are not always sensitive to the uniquely higher cost of northern health program delivery.

³ Walker, Liz. 2005. Position Paper: *Funding Inequities for Yukon First Nations Health and Social Programs (draft)*. Council of Yukon First Nations.

Introduction

This document discusses issues related to the federal funding of health programs to First Nations in Canada's territories. Both historically and currently, First Nations north of 60 have been subject to different practices regarding the funding and provision of federal health services compared to their provincial counterparts. This uniqueness is explored in relation to the jurisdictional, economic and demographic realities of First Nations health services in the territories. A discussion follows which presents issues that have contributed to funding inequities in First Nations health services, and includes Health Canada policies vis-à-vis territorial health funding, jurisdictional disagreements, allocation of program funding, eligible populations for federal programs, role of self-government, and First Nations capacity development in health service delivery.

Delivery of First Nations Health Services: Comparative Analysis

1. Legislative Authority for Health

The federal government has full legislative authority over the territories, a provision which was established in the *British North America Act* (1871 amended) and continued in the Canadian Constitution. In contrast to the provinces which have full legislative authority over health and other defined areas in the Constitution, the territorial governments are overseen by statutes, such as the *Department of Indian Affairs and Northern Development Act* (which defines the relations between the federal government and territorial administrations) and other Acts which allow the territorial administrations to have jurisdiction over certain areas that are typically provincial south of 60.⁴

The actual ability of the territorial governments to implement programs, such as those in the delivery of health services, is highly dependent on receiving necessary funds from the federal government. Whereas the provinces contribute the majority of public funds necessary for the delivery of health care in their jurisdictions, almost all of the funds for *Canada Health Act* services (i.e. hospital insurance and physician services) in the three territories are provided from federal coffers through the Canada Health Transfer (CHT) and Territorial Formula Financing (TFF) Agreement.

2. Mechanisms for Delivery of First Nations and Inuit Health Services

Provincial governments receive federal health funds for insured hospital and physician services through the CHT. The entire provincial population, including First Nations and Inuit, is used to calculate the amount of funds; therefore the federal government does provide health resources to provincial governments for First Nations both on and off reserve. In addition, First Nations receive federal funds directly for public health (community health nurses [CHN] and community health representatives [CHR]), health promotion and education (Canada Prenatal Nutrition Program [CPNP], Fetal Alcohol

⁴ Brown, D.E. 2000. *An Overview of the Evolution of Health Service Delivery Arrangements in the North*. Ottawa: Nelligan Power LLP.

Spectrum Disorder [FASD], Brighter Futures [BF], Building Healthy Communities [BHC], and Nutrition and Physical Activity Promotion [NPAP]), primary health care in remote locations, First Nations and Inuit Home and Community Care (FNIHCC), Non-Insured Health Benefits (NIHB) Program, and a range of community programs (National Native Alcohol and Drug Abuse Program [NNADAP], Youth Solvent Abuse Program [YSAB], Aboriginal Head Start On Reserve [AHSOR], First Nations and Inuit Tobacco Control Strategy [FNITCS], and Aboriginal Diabetes Initiative [ADI]). These funds are provided to First Nations through a number of financial mechanisms, from contribution agreements to health transfer agreements and self-government agreements [SGAs].

Historically in the territories, the federal government delivered health care to all residents including First Nations and Inuit who make up a large percentage of the population. This occurred because of the lack of capacity and infrastructure in territorial governments to deliver health care to a population which is sparse and widely dispersed. An additional reason likely was the significant proportion of the territorial populations which are Aboriginal, and the early and continuing involvement of the federal government in First Nations and Inuit health.

With the maturation of territorial governments and the accompanying desire to run their own affairs, defined health and other services were devolved from the federal to the territorial governments which then assumed the delivery of health services to their entire population including Aboriginal people.

Yukon

In Yukon, the federal services which were transferred to the Yukon Government (YG) were those which were administered universally to the entire population by Medical Services Branch (now First Nations and Inuit Health Branch [FNIHB]) of Health Canada, and included the Whitehorse hospital, nursing and public health. CHRs and health clerks were excluded from transfer, as they were employed by First Nations and not a federal service available for transfer. Programs which were not transferred were those which were directed solely to First Nations. Currently, these programs include NNADAP, BF, BHC, CPNP, management and support, Health Careers, HIV/AIDS, FASD, ADI (primary prevention and health promotion), FNIHCC, and FNITCS. First Nations receive funds directly from the federal government for these programs with administration through the Northern Secretariat, FNIHB via contribution agreements or integrated agreements. In the case of self-governing First Nations, NNADAP, BF, BHC, CPNP, management and support, and Health Careers are transferred from Canada through Programs and Services Transfer Agreements (PSTAs). In the past, if Health Canada enhanced programming, the additional funds were automatically forwarded to self-governing First Nations. Health Canada has indicated that a process is being developed to deal with the receipt of enhanced funding by self-governing First Nations. Indian and Northern Affairs Canada (INAC) is the lead with respect to general processes with SGAs.

In addition, Yukon and NWT First Nations are eligible for health program funding from the Public Health Agency of Canada (PHAC) which provides programs directed to the general population. These programs are delivered by the Northern Secretariat through a

memorandum of understanding with PHAC, and are generally accessed through proposals from territorial not-for-profit (NGOs) organizations and Aboriginal communities. NGOs often include Aboriginal people as a target population in their proposals for funding. PHAC programs include CPNP, Canada Action Program for Children, FASD, Population Health Fund, AHS, AIDS Community Action Program and Hepatitis C. Up until recently, PHAC also had a diabetes stream from the Canadian Diabetes Strategy. With the planned Integrated Strategy for Healthy Living and Chronic Disease, new programs will include the Healthy Living Fund, Diabetes Fund, and in the future, the Cancer Fund and Cardiovascular Fund.

NWT

The Government of the Northwest Territories' (GNWT) health transfer agreements with Health Canada excluded services where the GNWT did not have a comparable program for the non-Aboriginal population. The most significant difference from the post-transfer Yukon arrangements is the GNWT's administration (through contribution agreements) of Health Canada programs not included in the territorial transfer rather than a financing mechanism being set up between the federal government and individual First Nations. The NWT First Nations who receive these programs from the GNWT are the Gwich'in, Sahtu, Dogrib Treaty 11, Deh Cho and Akaitcho Territory. Currently, FNIHB has two consolidated contribution agreements with the GNWT. One is a "wellness agreement" and includes BF (note: aspects of BHC were merged into BF dollars), CPNP, NNADAP (treatment and training), FNITCS, and program management. The second contribution agreement covers care and treatment programs: FNIHCC, ADI and the home nursing component of BHC. The GNWT also manages the components of the NIHB Program which are not administered through First Canadian Health (e.g. portions of the dental and pharmacy benefits as well as the vision and medical transportation benefits).

PHAC program funding is administered by the Northern Secretariat to NWT First Nations similarly to that described above for Yukon First Nations.

Territorial Transfer Agreements

There have been five transfer agreements involving the federal government health and either the GNWT or YG related to health services:

- 1982: Frobisher Bay General Hospital (NWT);
- 1986: Agreement for the Transfer of the Baffin Zone Health Care Program (NWT);
- 1988: Northwest Territories Health Transfer Agreement (see Appendix 1 for a list of transferred programs). Note: programs not transferred include public service health, non-insured services,⁵ aviation medicine and immigration health;
- 1993 Whitehorse General Hospital Agreement (Yukon); and
- 1997: Yukon Universal Health Program Transfer Agreement: this agreement transferred the following positions: nursing (community health, general duty, nurse in charge, communicable disease and mental health), mental health

⁵ The NIHB Program was not referred to specifically, so it is assumed that the term "non-insured service" denotes any service which is not insured by the GNWT.

coordinator, clinical psychologist, medical officer of health, environmental health officer, as well as administrative and support staff.⁶

The last three agreements contain specific provisions meant to assuage concerns of Aboriginal groups that their rights to health services would be compromised by the transfer from the federal to the territorial government. The 1988 NWT agreement clauses serve as an example of all three agreements:

“Nothing in this agreement shall prejudice the aboriginal or treaty rights, if any, of the aboriginal people of the Northwest Territories to receive insured health services.

The parties agree that nothing herein shall deprive the aboriginal people of the Northwest Territories of the opportunity as it may be enjoyed by aboriginal people elsewhere in Canada to participate in and benefit from health policies and health programs designed for the aboriginal people of Canada.

Nothing in this agreement shall relieve the Government of Canada of any obligations it may have to deliver non-insured health benefits to Status Indian and Inuit people.”

In addition, the GNWT has a memorandum of agreement with INAC for additional annual resources directed to hospital and physician costs of First Nations and Inuit living in the territories.

Both the 1993 and 1997 Yukon transfer agreements acknowledged the support of the Council of Yukon First Nations (CYFN). In the NWT, First Nations were also supportive of the federal-GNWT health transfer initiative.

3. Ownership of Land

In the territories, First Nations typically reside on lands set aside, not on lands classed as reserves, in contrast to the provinces where reserves are the norm. Reserves do exist in the North, but with an occasional exception such as the First Nation of Teslin, they are not occupied. Three examples of recently established reserves relate to Treaty Land Entitlement (TLE) agreements in the NWT: the Hay River Reserve (1970's), Smith's Landing First Nation (2000), and Salt River First Nation (2002).

Lands set aside are defined as lands which are not designated a reserve under the *Indian Act*, but which are noted in the property records of INAC as set aside for the use and benefit of INAC's Indian and Inuit program. Reserve land, by contrast, is a tract of land that has been set apart for the use and benefit of Indian people pursuant to the *Indian Act*. The legal title to the reserve land is vested in the federal government.

⁶ In some cases, the positions transferred were minimal, for example, one communicable disease position, and one staffed clinical psychologist (the agreement notes that one psychologist position was vacant).

With the negotiation of land claim agreements in both Yukon and NWT, land included in these agreements is termed settlement land and such land is owned by the respective First Nation. Rights and benefits defined by the land claim agreement such as the rights to surface and sub surface resources or consultation on exploration or development of said resources, may extend to settlement land.⁷

4. First Nations Funding Mechanisms

In the provinces, Health Transfer has been used by the majority of First Nations as the mechanism to receive consolidated federal funds for health programs and services and also obtain flexibility in assigning health funds to community priorities. It is not self-government, rather gives greater control to communities over their health programming. The Health Transfer planning process is lengthy and involves the preparation of a community health plan.

First Nations in Yukon and NWT vary markedly in their involvement in health services, with the result that financing agreements relating to federal funds for health services handled are differently in these two jurisdictions:⁸

Yukon

In the Yukon, at the same time as the federal government was devolving services to the territorial government, comprehensive land claim agreements and SGAs were being negotiated with Yukon First Nations. The 1997 transfer agreement between the Government of Canada and YG specifically provides that the *Yukon First Nations Comprehensive Land Claim Final Agreement* and self-government final agreements would not be prejudiced in any respect by the transfer of federal services to the Yukon.

To date, eleven of fourteen Yukon First Nations have negotiated SGAs with the federal government and YG. These agreements have common provisions, for example, they all confer on the respective First Nations legislative power over a range of matters, including:

“provision of health care and services to Citizens, except licensing and regulation of facility-based services off Settlement Land;”

“licencing and regulation of any person or entity carrying on any business, trade, profession, or other occupation [on Settlement Land].”

First Nations retain the right to participate in and benefit from federal government programs:

⁷ www.ainc-inac.gc.ca Yukon Land Claims Glossary

⁸ Land claim agreements have been the initial focus of much of First Nations efforts in securing control of their land and programs in the territories, and were aided in 1974, with the establishment by the Government of Canada of a general process for resolution of land issues, through land, or comprehensive, claims negotiations – a modern day version of treaty making. This was followed in 1986 with a comprehensive land claims policy, with the stated purpose of negotiating and clarifying Aboriginal rights to lands and resources. Source: *NWT Plain Talk*. April 2000. Indian and Northern Affairs Canada.

“unless otherwise provided...this Agreement shall not affect the ability of Citizens to participate in and benefit from Government programs for status Indians, non-status Indians or native people, as the case may be...”

The financial ability of a First Nation to provide services to its citizens is ensured through the following provision that the federal government:

“[provide] the...First Nation with resources to enable the...First Nation to provide public services at levels reasonably comparable to those generally prevailing in the Yukon, at reasonably comparable levels of taxation.”

With the completion of a self-government financial agreement, the First Nation and federal government then can negotiate the transfer of federal responsibility to the First Nation, with the stated objective:

“to provide resources adequate to ensure that the program or service to be offered by theFirst Nation is of a level or quality equivalent to the government program or service and existing program or service quality is not diminished.”

In addition, payments under self-government financial transfer agreements are to be provided on an “unconditional basis” except where conditions are attached to the provision of funding for similar programs in other jurisdictions in Canada.

The PSTA is agreement used to transfer program responsibility and respective funding to self-governing First Nations. PSTAs include band management and housing, as well as the FNIHB programs: health services (CHRs and health clerks), NNADAP, BF, BHC, management and support, CPNP and Health Careers. To date, other FNIHB programs including HIV/AIDS, FASD, ADI, FNIHCC and FNITCS have not been transferred via the PSTA process, although they are eligible for draw down. At present, these latter funds are provided through contribution agreements.

Kwanlin Dun First Nation (KDFN, which is located within Whitehorse, receives funding for nursing services through a PSTA. This is an anomaly in that First Nations nursing services were transferred to the YG. KDFN had an existing administrative arrangement for provision of nursing services prior to the YG Health Transfer. This relationship with Health Canada continued and more recently, the KDFN negotiated the same services under the PSTA process. Nursing services in respect to the transferred programs of communicable disease control and immunization are defined within the PSTA and are done so in collaboration with the YG, which retains responsibility for jurisdiction as per the *Yukon Health Act* legislation.

NWT

In the NWT, First Nations have focussed on securing land claim agreements which ensure their special relationship with the land and the natural resources which have sustained them. Comprehensive land claim negotiation is the mechanism used to resolve

Aboriginal rights to land and resources, and in the case of the Dene, to implement land provisions in Treaties 8 and 11 signed with the Government of Canada in the early 1900s.

Settled First Nations land claims in the NWT include the *Gwich'in Comprehensive Land Claim Agreement*, *Sahtu Comprehensive Land Claim Agreement*, *Tłı̄ch̄k Land Claim and Self-Government Agreement*, and the TLE agreements with Smith's Landing and Salt River First Nations.

Once a land claim is completed, or concurrently with a comprehensive land claim negotiation, self-government may be negotiated which allows First Nations to enact laws and negotiate arrangements that reflect and protect First Nations' needs, cultures and values in diverse areas from health care and child welfare, to education, housing and economic development.

The sole signed SGA to date in NWT is the *Tłı̄ch̄k Land Claim and Self-Government Agreement* (2005). In the development of their SGA, the Tłı̄ch̄k chose to focus on the issue of lands and resources as a priority, followed by governance. The SGA has provided for a system of community governments which are similar to municipalities and are responsible for all residents of the communities, not just the Tłı̄ch̄k citizens. These community governments have the power to enact laws that are municipal in nature, in a similar fashion to other community governments in the NWT in a variety of areas: protection of cultural beliefs and traditions, heritage resources, training, social assistance, child and family services, adoption, education (not post secondary), wills and marriage among others. Health services are not included on this list, with the exception of the practice of traditional medicine of Tłı̄ch̄k citizens and the certification of such practitioners.

The Tłı̄ch̄k agreement contains a provision similar to Yukon SGAs regarding eligibility for government programs:

“nothing in the Agreement shall affect the ability of the Tłı̄ch̄k Government and Tłı̄ch̄k Citizens to participate in and benefit from government programs for status Indians, non-status Indians or Métis, as the case may be. Benefits received under such programs shall be determined by general criteria established from time to time.”

and

“Where government provides a health, education, welfare, family or other social program or service in the Northwest Territories, it shall provide the program or service

- (a) to Tłı̄ch̄k Citizens in a community in the Northwest Territories at a level comparable to that at which it is provided to all persons resident in that community;
- (b) in each Tłı̄ch̄k community at a level comparable to that at which it is provided in a similar community in the Northwest Territories.”

In the SGA process, the Tłı̨ch̨k government chose to negotiate a tripartite intergovernmental services agreement with the GNWT and Government of Canada to deal with health programming to its population. This agreement coordinates the delivery of program and services to Tłı̨ch̨k citizens, essentially ensuring the status quo in the health system.

The status quo with respect to health services does not appear to be the direction chosen by the Gwich'in and Inuvialuit in the NWT. The 2003 *Gwich'in and Inuvialuit Self-Government Agreement-in-Principle for the Beaufort-Delta Region (Northwest Territories)* has devoted a chapter to health and provides the mechanism for the Gwich'in and Inuvialuit governments to negotiate agreements with the Government of Canada to deliver and administer the NIHB Program and any federal Aboriginal health program that may exist from time to time. The Beaufort-Delta Regional Government may also negotiate agreements with the GNWT regarding their authority to:

- “(a) deliver health care programs and services;
- (b) manage, operate and control Health Facilities;
- (c) coordinate, plan for and manage health care programs and services; and
- (d) integrate health care programs and services with other programs and services.”

As well, any agreement negotiated on this basis would include provisions that “promote the integration, coordination and harmonization of the delivery of health care programs and services within the Beaufort-Delta Region and the Northwest Territories.”

The Beaufort-Delta Agreement-in-Principle does not contain the same provision ensuring eligibility for government programs in the future which is contained in the Tłı̨ch̨k Agreement and Yukon SGAs. It does include a similar principle that funding for programs and services will be at levels reasonably comparable to those generally prevailing in communities of similar size and circumstances in the Northwest Territories. The negotiation of fiscal financing agreements is to be guided by the principle that the territorial government will remain effective with the ability to delivery its programs and services to all residents of the NWT and affect economic and fiscal policies on a territory-wide basis.

5. Federal Policy Framework

FNIHB reviewed the funding of programs and services in the north from a policy context. Its review of past practices resulted in the following broad guidelines:

1. Funding which is an enhancement or expansion of a program that FNIHB currently funds should be continued;
2. New FNIHB programs which duplicate responsibility that has been transferred through the TFF and CHT should not be provided; and
3. New FNIHB health promotion and prevention programs which are national in scope should be provided.

FNIHB envisions the continuation of established methods for the delivery of health funds not included in existing territorial transfer agreements. The NWT mechanism is via contribution agreements with the territorial government. Yukon self-governing First Nations employ PSTAs with Canada for transferred programs, and contribution agreements with FNIHB for newer programs yet to be transferred. Non self-governing Yukon First Nations are financed via integration agreements. Whereas in the past, new or enhanced program funds have been simply added to PSTAs, recently, enhanced funds have been provided through contribution agreements.

An amended version of the Modified Berger formula is used nationally to allocate program resources among regions such as the MCH Program now being implemented. Appendix 2 contains a description of the formula. It includes adjustments for both diseconomies of scale (small community populations) and the increased cost of remoteness.

Discussion

The equity or inequity of Health Canada funding to First Nations in Yukon and NWT is a topic where there is little written information to draw from. Most Health Canada documentation is considered confidential and not sharable. Both Health Canada and First Nations stakeholders have been interviewed in the preparation of this report. The issues discussed in this report have been obtained, for the most part, through verbal communication. This document should be considered as a preliminary review of issues related to health funding of First Nations in the territories which will stimulate further discussion and sharing of issues.

1. Health Canada Policy

The three Health Canada policy guidelines described above are based on past practices and therefore may not reflect the needs and issues arising in the future with respect to new programming. The second guideline (*new FNIHB programs which duplicate responsibility that has been transferred through the TFF and CHT should not be provided*) is acknowledged by Health Canada to be contentious, and from the federal government's perspective, will prevent duplication of federally funded services with territorial health services, dubbed "double dipping." The fact of service provision acts as a precedent from which to judge duplication of responsibility, and in the federal government's opinion, is reasonable. The definition of a transferred service differs between federal and territorial jurisdictions with obvious implications for federal funding. From a financial perspective, it may not be in the interest of the federal government to advocate that a broad definition should be employed, and conversely, the territorial government, if wishing to maximize federal funding commitments, will interpret the transfer agreements in a narrower, limited fashion.

The CYFN has contested the premise that double dipping exists between federal and territorial health programs, noting that Yukon First Nations do not receive comparable

funding from the YG for the delivery of program and services otherwise meant to be provided through federal enhancements, nor do they receive territorial services in their communities which are comparable.⁹

Territorial First Nations hold the position that a double standard exists with the federal government regarding the exclusion of funds for the delivery of treatment services in the territories when compared to funding practices for provincially located First Nations. The provincial governments have responsibility for treatment services to their entire population, and First Nations populations are included in the CHT funding formula. That has not prevented FNIHB from entering into the realm of treatment services which are community-based, such as the new MCH program. The territorial governments also have responsibility for treatment services to their entire population, but in this case, FNIHB does not wish to make this exception and fund treatment-related MCH services to First Nations directly. The position of the federal government is that territorial health services are delivered in First Nations communities, whereas provincial governments cite federal jurisdiction and generally end their service provision at the First Nations boundaries. Notwithstanding the fact that Yukon First Nations would contest the claim that territorial services can be accessed within their communities (and not on settlement land identified in land claim agreements), as more and more First Nations in both the provinces and territories conclude land claims, treaties and/or SGAs with supporting contractual agreements for health service delivery, this distinction based on reserve versus non reserve will become somewhat esoteric.

At the time of the NWT transfer agreement, federal programs were often minimal; for example, preventative dental services were school-based, and the mental health program included a psychologist, nurse and clerk. This restricted scope of services in the transfer agreements has now been used by both the federal government and territorial governments (e.g. GNWT) as a means to limit responsibility for certain health services to First Nations. For example, the federal government's position is that preventative dental programs have been transferred, and therefore any further expansion in this area is the responsibility of the territorial government, whereas the GNWT maintain that they received only a school-based program and have no commitment to a larger dental prevention program to First Nations.

The NWT and Yukon transfer agreements differ in the descriptions of programs transferred from the federal government in 1988 and 1997 respectively. The NWT agreement contains both a listing of programs (e.g. mental health) accompanied by a staff list, whereas the Yukon agreement only includes a list of the actual positions (e.g. mental health nurse) without a broader description of the program. With respect to the latter agreement, Health Canada has interpreted the wording (e.g. position titles) to reflect entire programs. For example, the transfer of community health and communicable disease nurse positions in the Yukon has been interpreted as encompassing all treatment services provided to the community. The situation is clearer cut in the NWT transfer agreement as treatment is listed as a component of transferred community health services.

⁹ Letter from CYFN to Honourable Ujjal Dosanjh, Minister of Health, January 11, 2006.

The apparent transfer of treatment services has limited the amount of resources territorial First Nations can receive in the upstream health investments first announced by the federal government in September 2004. The new MCH Program has both prevention and treatment components. In the territories, only the prevention component of the MCH Program will be funded. Although at the time of the NWT and Yukon transfers, treatment in community health services generally meant either nursing or physician services, the definition of transferred treatment services has been applied much more broadly, as in the case of the MCH Program, to lay people, coaches and mentors who are to provide home-based care. These positions are integral to the roll out of the MCH Program to First Nations communities in the provinces, but funding for these workers will not be provided to First Nations in the territories.

Suicide prevention is one area where a liberal interpretation was successfully advocated by Inuit Tapiriit Kanatami through the National Inuit Committee on Health. They made a case that suicide prevention funding would augment territorial efforts, and as a result, the upstream investment in suicide prevention funding announced by the federal government in September 2004 was broadened to include Inuit and subsequently First Nations in the territories.

Territorial First Nations have not been successful in advocating for a portion of the recent First Nations Early Learning and Child Care (ELCC) investments from the federal government, program which is restricted to First Nations on reserve.¹⁰ This restriction has only recently arisen, as historically, Yukon First Nations were eligible for investments in Aboriginal child care initiatives.

2. Program Exclusions

The designation of First Nations lands in the territories as set aside, or if included in a land claim agreement, as settlement lands, has limited First Nations access to a considerable number of health programs from FNIHB which flow through policies specific to on-reserve First Nations and Inuit communities. Territorial First Nations have been excluded from the following programs that have eligibility for on reserve First Nations only:

- The treatment aspect of the MCH Program funding announced in September 2004 (after advocacy, the territories were approved for the prevention aspect, which comprises 30% of the funds received by First Nations communities in the provinces);
- Early Learning and Child Care (ELCC): The 2003 and 2004 federal budget provided \$45 million over three years and \$14 million ongoing for ELCC to First Nations on reserve. This was augmented in the 2005 federal budget by \$100 million over four years;
- E Health solutions: As territorial First Nations do not deliver nursing services, an electronic health information system was not seen as needed. In Yukon, an exception is Kwanlin Dun Health Centre in Whitehorse which includes nursing services and was funded for E Health;

¹⁰ Letter from CYFN to Honourable Ujjal Dosanjh, Minister of Health, January 11, 2006.

- Pandemic influenza planning: This funding is targeted to First Nations in the provinces where there is jurisdictional uncertainty over roles and responsibilities in public health services;
- Youth suicide prevention portion of upstream investments, although eligibility was extended to Inuit and First Nations in the territories only after extensive advocacy;
- Primary health care portion of any federal investments;
- Childrens' Oral Health Initiative (COHI), as dental health services were transferred to the territorial governments. After advocacy, this program has been extended to one Inuit project in Nunavut. More recently, the CYFN has received an assurance that the territories will be eligible for this initiative;
- FNIHB environmental health research;
- FNIHB environmental health contaminant program; and
- West Nile Virus, described as a south of 60 program.

3. Other Federal Financial Transfers

Yukon First Nations have noted that clarity has been lacking on the ability of self-governing First Nations to access other federal financial health transfers to the territories, such as the Aboriginal Health Transition Fund. As reported in the Yukon First Nations' Aboriginal Health Blueprint submission of November 2005, it was initially unclear as to whether the Aboriginal Health Transition Fund would accommodate Yukon First Nations.¹¹

In the NWT, First Nations have not been able to directly access reinvestment funds from the First Nations National Child Benefit. Under the National Child Benefit Initiative, the federal government increased the benefits it pays through the NCB Supplement to low income families with children, regardless of the source of their income. First Nations can reinvest the portion of this benefit which is directed to families on social assistance, into programs and services to low income families, such as child care, child nutrition, support for parents, home to work transition and cultural enrichment. In all provincial jurisdictions and Yukon, First Nations receive these funds for reinvestment, whereas in NWT, the First Nations funds are administered by the GNWT.¹²

4. Program Funding Allocations

Territorial First Nations have cited inadequate health program funding even for those areas where they are deemed to be eligible. Self-governing First Nations continue to advocate that program allocations accommodate the citizen population to which they have a responsibility for service delivery, rather than basing self-government funding on the status only population.

¹¹ Yukon First Nations 2005. *Yukon First Nations' Aboriginal Health Blueprint Action Agenda Submission*.

¹² Source: Telmo Des Santos, Dene Nation.

The issue of equitable program funding allocations is complex and will be considered in a separate document. Additional observations which are pertinent to this continuing discussion include:

- PHAC uses a different funding formula than FNIHB for similar programs. This is evident in AHS, where the PHAC formula results in lesser dollars for territorial First Nations compared to provincially-based First Nations funded through FNIHB. Due to advocacy by the Northern Secretariat regarding the need for equality in this program, a one time top up was secured for AHS programs in the territories (and was called the Northern Equity AHS). However, it is not known if, with the expanded First Nations ELCC program initiative, the North will have equity in resource allocation or will receive comparatively lesser funds from PHAC.
- Whereas in the provinces, First Nations community population numbers which are used to calculate FNIHB program funding allocations reflect all persons living on reserve (not merely status), for self-governing Yukon First Nations, only the status First Nations are used to determine the level of self-government financing. One exception is the Kwanlin Dun Health Centre in Whitehorse – as the KDFN provided nursing services, total catchment population was used. The 2004/05 Health Canada population database shows the large difference between status persons and total residents in Yukon First Nations (Table 1). This database is not up-to-date, as it contains the same population numbers for Yukon as the 2001/02 version. However, it does illustrate the sizeable number of persons in some First Nations communities who are not status. As can be seen from Table 1, the percentage of status First Nations varies from 16.2% in Dawson to 90.5% in Old Crow.

Table 1
Yukon First Nations Population
Health Canada Population Database, 2004/05

	# Status residents	# other residents	Total	% status
Dawson	332	1717	2049	16.2%
Mayo	239	357	596	40.1%
Old Crow	257	27	284	90.5%
Lower Post (Yuk)	176	11	187	94.1%
Mt. McIntyre	1423	181	1604	88.7%
Watson Lake	660	1133	1793	36.8%
Beaver Creek	67	103	170	39.4%
Carcross	305	428	733	41.6%
Carmacks	303	158	461	65.7%
Destruction Bay	86	260	346	24.9%
Haines	277	602	879	31.5%
Pelly Crossing	270	53	323	83.6%
Ross River	314	84	398	78.9%
Teslin	254	280	534	47.6%

Note: Lower Post receives Health Canada services via the northwest region of British Columbia.

Because of the small populations in these communities, the actual amount of resources that are provided to First Nations in the territories can be miniscule. For example, Yukon First Nations qualify for \$55,000 in the prevention component of the MCH Program's first year. This amount is spread among all fourteen First Nations. And as it is population-based, the small First Nations receive extremely small allocations, with the largest First Nation (Kwanlin Dun in Whitehorse) receiving in the range of 30-40% of these funds. Another example is the ADI, a community-driven program with coordination by CYFN. The regional allocation for ADI is \$152,000. Of this, the annual amount of \$110,000 is allocated to CYFN for ten communities. Each community gets about \$8,000, and it should be noted, also has a significant reporting burden associated with this small amount of funds.

- A portion of federal health funds are taken for administration by the Northern Secretariat which limit the amount of resources which reach the communities. It can be argued that the Northern Secretariat has similar needs to other regional FNIHB offices when administering programs; however the low population of First Nations and the correspondingly small amount of total resources available means that regional administration costs may be felt more acutely by territorial First Nations.

5. Self-Government

Self-government provides the mechanism for First Nations to assume control of their health and social programs in both Yukon and NWT. According to Health Canada, in many respects, SGA agreements are similar whether First Nations are located in provinces or territories. At issue is 'what is on the ground' – the existing financial arrangements already in place between Health Canada and the First Nation in question. The general rule is that a SGA can include only existing programs and resources.

Because the territorial governments administer some of Health Canada's programs, and in other cases health program funds have been included in the TFF, the range of programs which could be readily available for inclusion in the First Nations SGAs in the territories has been more restricted than for First Nations negotiating self-government in the provinces. Yukon First Nations are pursuing an option to add program funding, such as ADI, FASD, MCH and suicide prevention, under section 17 of their SGAs. These programs are time-limited, not available for transfer south of 60 and are not subject to the 3% annual Health Canada program growth. These program conditions add a wrinkle when crafting a self-government amendment; however, the recent Labrador Inuit Association (Nunatsiavut) self-government process was able to arrive at a fiscal agreement where all programs are included. In the Nunatsiavut agreement, only those Health Canada programs that are within its envelope have annual growth.

In NWT, interest has been expressed by some First Nations for a fiscal arrangement which includes Health Canada funds now administered by the GNWT.

SGAs do not exhibit uniformity between south of 60 and northern financial transfer agreements (FTAs) with respect to the formula used to calculate future growth of federal fund transfers. For example, in British Columbia, the *Nisga'a Nation Fiscal Financing Agreement* contains the following escalators for federal funding:

- Budget Adjustment Factor: the year over year percentage growth in annual funding for the Indian and Inuit Affairs Program of INAC, as provided in the applicable federal budget for that year. (This has been 2% since 1997/98.)
- Price Adjustment Factor: an annual adjustment based on the Canada Final Domestic Demand Implicit Price Index, series B15613 (Statistics Canada); and
- Composite Population Adjustment Index: based on the total population adjustment factor which is equal to 1 plus the average annual growth rate of the total Nisga'a population for the latest 5 year period AND the cohort population factor which reflects the difference between the average annual growth rate for specific age cohorts within the Nisga'a population and the average annual growth rate for the Nisga'a population as a whole (for health funding, these cohorts are the 0-4 and 55+ age groups).

For self-governing First Nations in Yukon, escalators to be applied to funds received under FTAs, can be either a price adjustment or a combination of price and population adjustments. The adjustment to be used is specified in the PSTA and is operationalized in the First Nation's FTA. The price adjuster is calculated as a three year average of the Final Domestic Demand Implicit Price Index. The population adjuster is set at 3% pending the development of an accurate census measure for First Nations in the territories. In 2005/06, the price adjuster was 1.01621. The combined price and population adjuster was $1.0621 \times 1.03 = 1.046963$.

Once the final adjuster is calculated, then it is applied to the First Nation's Gross Expenditure Base (GEB, which is the total of all the relevant annual funds in PSTAs, land claim agreements, and implementation agreements of land claim agreements) to arrive at a current GEB. This total is then reduced by an offset amount which acknowledges First Nation's revenue sources, namely taxation and resource royalties. The offset amount is calculated using a factor to be multiplied by the sum of eligible revenue for that year. In a new FTA, the offset factor is set at zero for the first two years, and thereafter gradually increases, for example, .30 in the third year, .35 in the fourth year, .40 in the fifth year, .45 in the sixth year and .50 in the seventh year.

To date, PSTAs have included INAC and Health Canada programs. Generally, the Health Canada program funds are adjusted by both price and population adjusters. An FTA can contain a number of PSTAs, which may vary according to whether they incorporate a price-only adjuster or a combined price and population adjuster.

A mechanism has been described for self-governing Yukon First Nations to receive funds for INAC programs now funded to the YG through the TFF. The Yukon Northern Affairs Program (NAP) Devolution Transfer Agreement provides that the amount of funding for a NAP-related PSTA to be withdrawn from the territorial governments' GEB shall equate to the final amount of funding including the annual escalation (the

population adjusted gross expenditure escalator or PAGE) being provided to the YG under its TFF. This in essence states that NAP-related PSTAs for funds which originate in the TFF and which are negotiated after the NAP, receive at a minimum the same escalator as the TFF. Further, the Agreement states that the Government of Canada is obligated to provide to the First Nation, any difference between the funding amount adjusted by PAGE used in TFF and the funding amount adjusted by an escalator in a future NAP-related PSTA.

In the territories, the only self-governing First Nations which now receive financial transfers to administer health programs under PSTAs are in Yukon, as the one self-governing NWT First Nation (Tłı̨ch̨k) has chosen the approach of intergovernmental service agreements for health services.

In the interviews undertaken for this report, some respondents observed that the lack of a consistent process which includes Health Canada, INAC, territorial governments and First Nations may result in an environment where a variety of financing arrangements can be struck with First Nations, and there is no unified First Nations voice to ensure that future health (and other) program funding needs are not just acknowledged, but are presented in a clear phraseology which ensures commonly agreed upon interpretations. For example, the Yukon First Nations SGAs contain the clause:

“unless otherwise provided...this Agreement shall not affect the ability of Citizens to participate in and benefit from Government programs for status Indians, non-status Indians or native people, as the case may be. Benefits under such programs shall be determined by the general criteria for such programs established from time to time. Programs which apply to Yukon Indian People residing on a Reserve or on Land Set Aside shall not cease due to the fact the land becomes Settlement Land pursuant to a Yukon First Nation Final Agreement.”

At face value, this clause appears to protect self-governing First Nations from being excluded from new federally funded programs, and ensures that access to program enhancements will occur on the same terms as the enhancements which are generally available elsewhere in the country. However, the clause has been interpreted by some federal officials as directed to Aboriginal programs of general application, not First Nations on-reserve programs. Given that FNIHB no longer uses the informal general description of its target population as First Nations on reserve and north of 60, and rather refers to “First Nations on reserve and Inuit communities,”¹³ this federal interpretation supports the non eligibility by territorial First Nations to new FNIHB programs.

Furthermore, there is no notification requirement in either land claim agreements nor SGAs for the federal government to communicate with self-governing First Nations about new program funding opportunities. The federal government may unilaterally decide that territorial First Nations are not eligible for a new program. As an example, initially COHI was not formally communicated to First Nations or Inuit in the territories.

¹³ This latter terminology is used extensively in describing FNIHB programs in: First Nations and Inuit Health Branch. 2005. *Mapping of Health Canada Programs for Aboriginal Health*.

In the general information on the initiative, it is described as addressing the disparity between the oral health of First Nations and Inuit and the general Canadian population.¹⁴ As it is a prevention/promotion program and preventative dental services were transferred in the Yukon and NWT health transfer agreements, territorial First Nations and Inuit were initially considered non-eligible by the federal government. The difference of opinion as to the scope of transferred dental services in the NWT has been described above. That this decision on non-eligibility could be counter productive to FNIHB financial bottom line given the significantly poor dental health of children in the north was considered after advocacy by the Northern Secretariat. Eligibility for COHI's first year pilot funding was extended late to Inuit in Nunavut – a population where \$2 million was recently spent on hospital based extractions to children as young as five years of age. First Nations in the territories who also have high emergency extraction rates in children remain non-eligible. As noted above, eligibility for COHI is now being considered for the territories.

Yukon SGAs provide First Nations with authority for health care to all citizens in their territories, including status and non status. Despite being removed from the *Indian Act*, self-governing First Nations still only receive FNIHB (and INAC) funds based on status Indian population numbers, with potentially serious ramifications on health program delivery by communities in the future – either health programs will be limited or unrecognized contributions to ensuring program sustainability will be required from limited own source revenues.¹⁵

The use of status only population numbers as a basis for FNIHB self-government financing in the Yukon will undoubtedly mean diminishing resources over time. The impact of Bill C31 on denying status to First Nations children who have mixed status and non-status grandparents (maternal and paternal) is only now being felt. INAC's Indian Register population projections for children younger than age ten predict that this age group will increase in numbers by only 0.9% between 2006 and 2007 and will decrease by 1.0% between 2020 and 2021.¹⁶ The NIHB Program which consumes over half of FNIHB resources nationally, is a status only program. At this time, 30% of self-governing First Nations are not status and therefore not eligible for NIHBs.¹⁷

With respect to health programs, the treaty involving the Nisga'a in British Columbia has led to health funding agreements with both the federal and provincial governments and provision of health services to the entire population in the territory, not only First Nations. The *Nisga'a Final Agreement*, the treaty signed by the Nisga'a Lisims Government, Province of British Columbia and Government of Canada. Chapter 11 (85) under Health Services, states:

“At the request of any Party, the Parties will negotiate and attempt to reach agreements for Nisga'a Lisims Government delivery and administration of federal and provincial health services and programs for all individuals residing within

¹⁴ http://www.hc-sc.gc.ca/ahc-asc/activit/strateg/fnih-spni/cohi-isbde_e.html

¹⁵ Walker, L. 2005.

¹⁶ Population Projections of Registered Indians, 2000-2021, DIAND, 2002.

¹⁷ Yukon First Nations. 2005.

Nisga'a Lands. Those agreements will include a requirement that Nisga'a citizens and individuals who are not Nisga'a citizens will be treated equally in the provision of those health services and programs."

The Nisga'a Valley Health Board provides both population health (public health) and personal health (prevention, treatment, rehabilitation and support services) to residents in five villages, one of which is a non-native community.¹⁸

Under the terms of its financing agreement, the Nisga'a Nation is responsible for federally funded community health programs and services: senior care, rehabilitation services, community healing programs, public health services, and in-home care for its Nisga'a citizens resident on Nisga'a lands, and NIHB for all Nisga'a citizens resident in Canada. Through the Nisga'a Valley Health Board, provincially funded physician and treatment services are provided to *all* occupants of Nisga'a lands (including non-Nisga'a), and consist of primary care outpatient services, and after hours emergency consultation and treatment services. The Board receives provincial funding for diagnostic and treatment centre services, including outpatient clinics, laboratory, radiology and medical emergency services, and family violence programs,¹⁹ Provincial funding comprises 12% of the health budget.²⁰

The Nisga'a Nation is responsible for the maintenance of its population database under the financing agreement. The Nisga'a communities are included in Health Canada's population database which tracks status and non status populations in First Nations communities and is used to determine program funding levels.

6. Annual Growth of Health Program Resources

In a review of a previous draft of this document, a question was raised with respect to the source of federal funds with which First Nations theoretically would be "better off" receiving, that is, assuming that they would receive full benefit of funds irrespective of where the funds originated. The three main sources of federal funds for First Nations health services presently are:

1. Indirectly as benefits through services received from the territorial government, which have been funded through the TFF;
2. Directly through funds received from Health Canada via a financing agreement, such as integrated agreement, or indirectly as benefits received from services of the territorial government which have been funded from Health Canada through contribution agreements; and
3. Directly through funds received from Canada through a PSTA (self-governing First Nations only).

¹⁸ www.nisgahealth.bc.ca/core/core/asp

¹⁹ Nisga'a Nation Fiscal Financing Agreement 2000.

²⁰ Lemchuk-Favel, L and R. Jock. 2004. "Aboriginal Health Systems in Canada." *Journal of Aboriginal Health*. 1(1): 28-53.

TFF Growth

A description of TFF growth requires a brief explanation of the mechanism to calculate this federal transfer to the territories. The TFF, prior to 2004, was calculated in a manner which reflected the fiscal capacity of the territories.²¹ Rather than looking at the revenue capacity of the territory solely, the territories' GEB was based on what the territories needed to spend in order to provide its residents with reasonably comparable public services. The GEB was benchmarked according to the actual expenditures of each territory in the base year, set at 1982.²² This benchmark was escalated year by year to reflect the growth in programs and services over time of provincial and local governments, and adjusted to include the change in each territory's population relative to the entire Canadian population, resulting in the PAGE.²³

Once the current GEB was calculated using the PAGE adjustment, it was reduced by the amount of territorial own source revenues and transfers other than TFF (such as CHT, Canada Social Transfer and other smaller federal transfers). This calculation of own source revenues was complex and was based largely on what a territory could potentially collect if it exerted a reasonable tax effort.²⁴ Therefore, the actual increase in the TFF was rarely the same as the PAGE, and could be either higher or lower depending on that territory's current revenue capacity.

Table 2 and the corresponding Figures 1 and 2, provide a review of the PAGE and TFF growth annually from 1985/86 to 2006/07 for Yukon and NWT respectively. In Yukon, the TFF growth has generally exceeded the PAGE, exceptions being the period 1994/95 to 1996/97 and 2004/05. Excluding 1985/86 where the TFF increase was 42.5% and can be considered an outlier, the average TFF increase in Yukon to 2006/07 was 6.0%, and the average PAGE from 1986/87 to 2004/05 was 3.8%

In NWT, a large fluctuation in the TFF values occurred between 1999/00 and 2001/02 and can be attributed to the creation of the new territory of Nunavut and the readjustment of federal transfers between NWT and Nunavut. Excluding these years, both TFF and PAGE have tended to exhibit lesser year-to-year fluctuations than the Yukon data, but the same trend of TFF growth being greater than PAGE is seen. With the noted exclusions, the average TFF growth between 1986/87 and 2006/07 was equal to Yukon at 6%. The average PAGE was essentially the same as Yukon's at 3.9% for the time period 1986/87 to 2006/07.

²¹ From 2004/05 to the present, a set amount of funds has been provided by the federal government to the North, and has been allocated to each territory based on previous funding history.

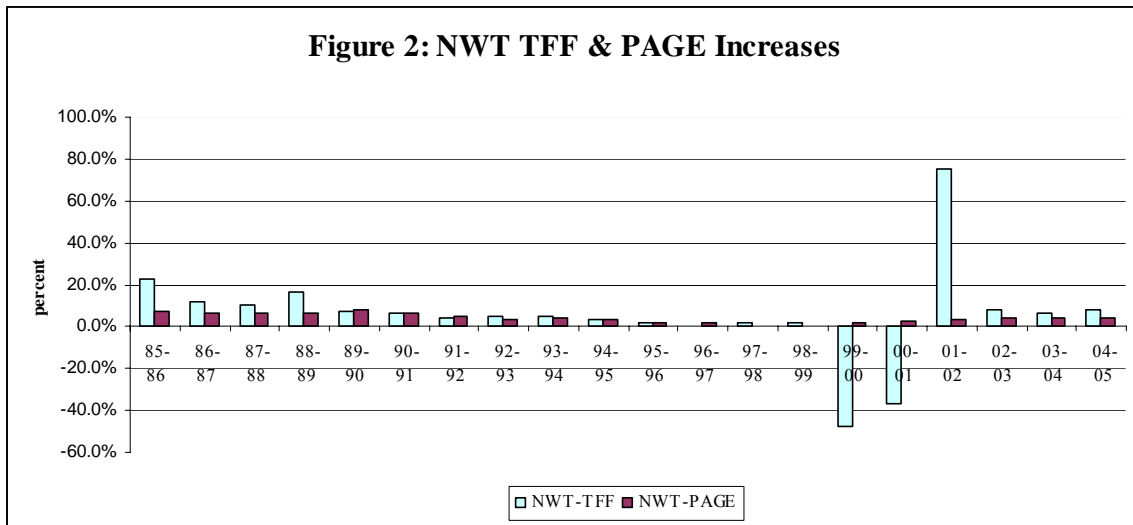
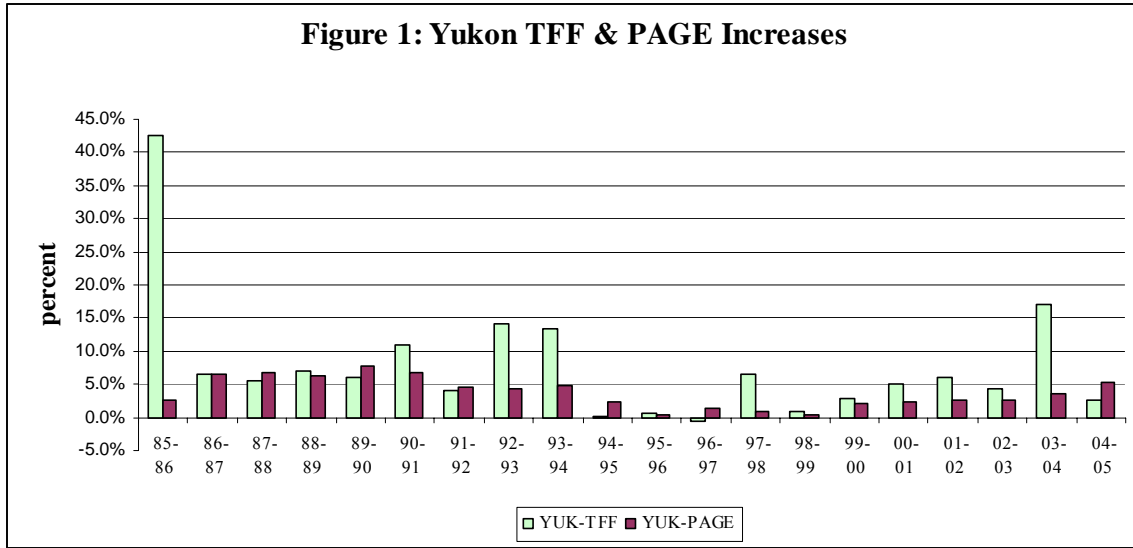
²² There have been two other adjustments to the GEB subsequent to the creation of the TFF: (1) every time a territory takes over a new program responsibility such as from INAC or Health Canada, the GEB was raised by the negotiated amount; and (2) the GEB was adjusted as necessary so that new incentives which affected the revenue side of the formula would not affect the size of the TFF.

²³ The population escalator was introduced in 1990.

²⁴ Reasonable for formula purposes is 85% of the national average tax rates of the provinces. This adjustment is meant to recognize, that, because of the differences in the northern and southern economies, the same tax rate would represent a higher effective tax burden on northern Canadians because of the higher cost of living in the North. Source: Expert Panel on the Review of Equalization and Territorial Formula Financing. 2005. Key issues for the review of Equalization and Territorial Formula Financing. www.eqttf-pfft.ca/english/issuespaper9.asp

**Table 2: Annual Increases: TFF and PAGE
Yukon and NWT, 1985/86 – 2006/07**

	Yukon TFF	Yukon PAGE	NWT TFF	NWT PAGE
1985/86	42.5%	2.6%	22.5%	7.6%
1986/97	6.5%	6.6%	11.7%	6.6%
1987/88	5.6%	6.8%	10.3%	6.8%
1988/89	7.0%	6.3%	16.8%	6.3%
1989/90	6.1%	7.7%	7.5%	7.7%
1990/91	10.9%	6.8%	6.3%	6.5%
1991/92	4.2%	4.6%	4.5%	4.8%
1992/93	14.2%	4.2%	5.1%	3.5%
1993/94	13.4%	4.7%	4.9%	3.8%
1994/95	0.1%	2.4%	3.6%	3.4%
1995/96	0.5%	0.5%	1.6%	1.9%
1996/97	-0.6%	1.3%	0.2%	1.9%
1997/98	6.5%	0.8%	1.5%	0.1%
1998/99	0.9%	0.4%	1.5%	0.5%
1999/00	3.0%	2.2%	-47.3%	2.0%
2000/01	5.1%	2.3%	-37.1%	2.9%
2001/02	6.0%	2.5%	75.3%	3.6%
2002/03	4.4%	2.6%	8.3%	4.0%
2003/04	17.0%	3.6%	6.4%	4.0%
2004/05	2.5%	5.4%	8.3%	4.4%
2005/06	9.2%		5.3%	
2006/07	3.9%		3.5%	



Health Canada Growth

FNIHB expenditure data was obtained for the territories and south of 60 regions for the years 1999/00 to 2005/06, and is detailed in Table 3. A large fluctuation in territorial expenditures occurred between 1999/00 and 2001/02 as year-to-year growth dipped 23% in 2000/01 before increasing 85% in 2001/02. This is in part due to the implementation and/or enhancement of programs such as FNIHCC and CPNP during this period.²⁵ In the remaining years of 2002/03 to 2005/06, FNIHB expenditure growth in the territories ranged from 2.1% to 9.2%, and was lower than south of 60 growth for three of these four years.

²⁵ An explanation for this fluctuation of expenditures has been requested from Health Canada, and will be included in a future draft of this report.

In addition to the expenditures listed in Table 3, the territorial governments received a commitment for \$30 million annually for five years starting in 2005/06 as a follow up from the 2004 First Ministers Meeting. These funds are to address the issue of medical transportation costs in the North and the need for transformative change in the health system. As these funds are not exclusively directed to First Nations and Inuit, rather they are to benefit the entire territorial population, they have not been included in this FNIHB expenditure analysis.²⁶ It should be noted that the \$30 million fund is administered by FNIHB and is listed as a FNIHB expenditure by Health Canada.

Table 3
Annual Percent Growth
FNIHB Expenditures

	Territories		South of 60	
		% change		% change
1999/00	\$47,531,098		\$1,067,854,582	
2000/01	\$38,838,871	-22.5%	\$1,218,729,047	14.1%
2001/02	\$68,270,015	85.3%	\$1,261,284,898	3.5%
2002/03	\$74,528,464	9.2%	\$1,374,548,419	9.0%
2003/04	\$77,871,300	4.5%	\$1,456,988,221	6.0%
2004/05	\$84,210,145	8.1%	\$1,579,464,056	8.4%
2005/06	\$85,952,622	2.1%	\$1,644,951,937	4.1%

Table 4
Annual Percent Growth
FNIHB Expenditures – Community Programs Only

	Territories		South of 60	
		% change		% change
1999/00	\$29,483,647		\$669,058,245	
2000/01	\$19,641,817	-33.4%	\$778,421,081	16.3%
2001/02	\$46,546,582	137.0%	\$775,975,995	-0.3%
2002/03	\$49,465,529	6.3%	\$842,766,881	8.6%
2003/04	\$50,615,380	2.3%	\$886,278,811	5.2%
2004/05	\$53,032,329	4.8%	\$981,013,195	10.7%
2005/06	\$54,498,918	2.8%	\$996,563,191	1.6%

In Table 4 above, the same FNIHB analysis is provided as in Table 3, except the NIHB Program expenditures have been removed to leave expenditures for Community Health

²⁶ A more appropriate placement of the \$30 million would be in the TFF as it is a territory-wide benefit. The combined total of Yukon and NWT TFF transfers is approximately \$1.2 billion, and an infusion of \$30 million would not result in significantly different values for TFF and PAGE increases provided in Table 4.

Programs (CHPs). In the past, the NIHB Program commonly experienced high annual growth, obscuring the lesser growth in other Health Canada programs. Since 2002/03, all years' CHPs increases in the territories are lesser than the increases seen with total FNIHB expenditures, and range from 2.3% to 4.8% annually.

Table 5 compares the TFF and Health Canada annual increases for 2002/03 to 2005/06 for Yukon and NWT. Both total FNIHB expenditures and CHP-only expenditures have been included. Values which are the highest in a given year have been bolded. Although TFF has provided the highest annual increases in three of four years, on a territory by territory basis, there is no observable pattern, with FNIHB total expenditures at the top in 2002/03 (9.2%), Yukon – TFF in 2003/04 (17.0%) and 2005/06 (9.2%), and NWT – TFF in 2004/05 (8.3%).

If looking at each territory specifically, the FNIHB expenditure increase (both total and CHP only) was greater than the Yukon – TFF increase in 2002/03 and 2004/05. NWT – TFF increases were greater than FNIHB in all years except 2002/03, where the FNIHB expenditure increase was the highest, when including both NIHB and CHPs.

Table 5
Annual Percent Growth, 2002/03 to 2006/07
TFF (Yukon and NWT) and FNIHB (Territories)

	Yukon – TFF	NWT – TFF	HC FNIHB - Territories	HC Community Health Programs
2002/03	4.4%	8.3%	9.2%	6.3%
2003/04	17.0%	6.4%	4.5%	2.3%
2004/05	2.5%	8.3%	8.1%	4.8%
2005/06	9.2%	5.3%	2.1%	2.8%
Average	8.2%	7.1%	6.0%	4.1%

PSTA Growth

As described above under Self-Government, the calculation of PSTA annual increases has similarities to TFF in that annual adjustments are made to the First Nations' GEB to arrive at a current GEB, then this amount is reduced by an offset amount which is a percentage of First Nations' revenue sources.

An anonymous example of a First Nation's federal transfer from 2002 to 2006 was provided for this report. In this particular case, where the offset amount increased five fold over the time period, the average annual increase of the PSTA was 1.57%, despite price and population adjusters of greater than 4% annually. In comparison, Yukon and NWT PAGE values averaged 3.9% and 4.1% respectively from 2002/03 to 2005/06. However, the PAGE values were both lower than what the territories ultimately received over this time period: an average of 8.2% TFF increase in Yukon and 7.1% TFF increase in NWT. Certainly, one First Nation's federal transfer example cannot be considered representative of all self-governing First Nations in the North, but it does illustrate that

First Nations' own source revenue can have a significantly greater impact on lowering federal transfer growth compared to that typically seen with territorial governments. This could be a result of the smaller PSTA funding levels in relation to the potential of First Nations' own source revenue growth. Another contributing factor could be the complexity of the TFF calculation which included a (1) tax effort adjustment factor that was directed to making sure that territorial revenue reflected reasonable tax efforts; and (2) an economic development incentive which ensured that the territorial governments would not be unduly penalized in the formula for economic growth and increases in their own-source revenue which could otherwise occur because of the formula's actual-to-potential revenue adjustment.²⁷

Beginning in 2004/05, territorial grants were no longer determined by the formulas in the three separate TFF agreements. The territories receive proportions in a set northern-wide federal transfer amount based on their recent transfers. A new territorial formula is being developed for 2007/08 and beyond.²⁸

Summary

The comparative expenditure analysis has shown, that for the most recent four year period of 2002/03 to 2005/06:

- (1) FNIHB annual expenditure increases have been lower in the territories than in the south of 60 when considering CHP only, and for three of four years when considering combined CHP and NIHB expenditures;
- (2) annual TFF growth to territorial governments has, on average, increased more than what the basic escalator (PAGE) would provide; and
- (3) annual TFF growth has been greater than that of FNIHB's CHP for all four years, and greater than combined CHP and NIHB growth for three of these four years.

For First Nations under PSTAs, the **maximum** growth possible for these four years averaged 4.9% based on the Canada final domestic demand implicit price index and 3% population growth, and in actual values, is somewhat less depending on the level of First Nations own source revenues. However, even if considering the **non-adjusted** 4.9% escalator, the PSTA average growth has lagged behind TFF growth (average of 8.2% for Yukon and 7.1% for NWT), and also is lower than the overall FNIHB expenditure growth (average of 6.0%). The non-adjusted average PSTA escalator is higher only than FNIHB CHP growth (average of 4.1%), and once own source revenues are taken into account, is likely lower in this comparison as well.

7. First Nations Capacity Development

This paper is primarily about funding issues experienced by territorial First Nations, not the state of land claim and/or SGA negotiations in the north *per se*. However, the ability of First Nations to successfully bring attention to perceived inequities in health

²⁷ Expert Panel on Equalization and Territorial Formula Financing. *Key Issues for the Review of Equalization and Territorial Formula Financing. Annex B.* www.eqtf-pqtf.ca/english/issuespaper9.asp

²⁸ <http://www.fin.gc.ca/FEDPROV/tffe.html>

resourcing and achieve change is a function of their credibility in matters of governance, knowledge of health services and involvement in the health system. A discussion of First Nations progress in these areas is therefore pertinent when looking at root causes and solutions to funding inequities.

First Nations, even those who are self-governing, face challenges in being recognized as equal partners in discussions on health services, not merely as stakeholders who must be consulted prior to government making unilateral decisions on services.²⁹ Health Canada has demonstrated a preference to deal with and recognize the GNWT rather than First Nations directly with respect to FNIHB health programs. Verbal reports from First Nations representatives who were consulted in these transfer and contribution agreements have indicated First Nations supported transfer of services to the GNWT as an interim measure. At the time, First Nations did not have land claim agreements and none had SGAs, which placed these groups in a position with little negotiating power and contributed to an environment for GNWT to assume authority.

Even though First Nations were forward looking with respect to an expectation of future assumption of health programs, the agreed-upon GNWT arrangement has prevented them in the succeeding years from moving substantively toward this goal. With the GNWT firmly in control of the delivery of health services, there has been little opportunity for First Nations to build capacity in this area. Some program dollars do flow from the GNWT to the community for administration, for example in NNADAP, but in other areas such as CHRs and the FNIHCC Program, associated staff are employees within the GNWT Ministry of Health and Social Services.

There has also been little First Nations involvement in the management of the components of NIHB Program which are administered by the GNWT under a contribution agreement. In this respect, First Nations benefits have been merged with general GNWT programs under the principle of universal health care. For example, vision and dental health programs are provided in the same fashion to all NWT residents for reasons of economies of scale, small population numbers and high cost of service delivery in the north. From a First Nations perspective, there is no demonstrated accountability or transparency in how federal dollars are spent, in particular, to verify if all of these resources are spent on First Nations, or if there is partial subsidization of services to non-First Nations.

NWT First Nations have had other priorities overriding the assumption of health service delivery to its citizens, namely the successful negotiation of land claim agreements, and secondly, SGAs which incorporate sound governance, which are necessary precursors to administering health programs. These agreements lay the framework for a consideration of health and social services. In some cases, a First Nation may prioritize control over child and family services rather than health services, particularly as GNWT has responsibility for placement and adoption of children and may make decisions on care differently than a First Nations-controlled program.

²⁹ Council of Yukon First Nations. Undated. Appendix B: Background Paper: Self-Governing Yukon First Nations – Health and Social Services.

A recent review of the NWT health and social services systems has concluded that the outcome of land claim and SGA negotiations will have an impact on the future design and delivery of health and social services. The author of this review notes that First Nations will have to weigh the pros and cons of assuming control over what might be minimal programs (federally funded) versus ensuring access to the entire range of health and social services as needed from the territorial system. The GNWT has indicated a preference for delegated authority in health services (e.g. intergovernmental service boards of the Tłı̄chh SGA is one example), however the Beaufort-Delta self-government agreement-in-principle with the Gwich'in and Inuvialuit points to the establishment of concurrent jurisdictions involving both GNWT and First Nations services. A number of hurdles would have to be addressed in any negotiation concerning the devolution of health services to First Nations. These include the opening of the 1988 transfer agreement and the memorandum of understanding between GNWT and INAC (the latter would be necessary to secure physician resources), the need to consider all residents of a geographic area not just First Nations in the service catchment population, and the separation of services which can best be delivered and managed locally from those which are optimally left at a territorial level whether for reasons of scarcity of specialized resources or pure economies of scale.³⁰

In the Yukon, First Nations were not given specific resources to develop community health plans prior to negotiating PSTAs, rather a lump sum of \$100,000 per First Nation was provided for general implementation support.

Lack of capacity has had an impact on the ability of First Nations to successfully compete for proposal-based program funding from PHAC. AHS has been the most accessible PHAC program to territorial First Nations. For example, of the 35 projects funded to NWT Aboriginal organizations in the three years from 1996/97 to 1998/99 from Health Promotion and Programs Branch (the precursor of PHAC), 32 were related to AHS.³¹

In the Yukon, PHAC program funding, apart from AHS, is accessed more successfully by non-First Nations, and First Nations funded projects are more likely to be located in Whitehorse. In the four-year period 1995/96 to 1998/99, seven of the 27 funded Health Promotion and Program Branch projects in Yukon were submitted by Aboriginal organizations, of which four were located in Whitehorse.³² This imbalance does not appear to have changed more recently, as smaller Yukon First Nations still have issues with lack of infrastructure and capacity to prepare proposals. PHAC funds are more likely to be placed with NGOs who state that they will address the Aboriginal population needs.³³

³⁰ George B. Cuff and Associates. 2001. *Executive Summary: It's Time to Act. A Report on the Health and Social Services System in the Northwest Territories.*

³¹ Lemchuk-Favel, L. 1999. *Financing a First Nations and Inuit Integrated Health System. Report 2: The Territories.* Ottawa: Health Canada.

³² Lemchuk-Favel. 1999.

³³ Interview with Lori Duncan, CYFN, January 27, 2006.

Summary

Any discussion on federal health funding to First Nations must acknowledge the historical relationship between First Nations and the Crown evidenced through treaties and the medicine chest clause. Even with the federal-territorial health transfer agreements, First Nations assert that residual Health Canada responsibilities remain for First Nations health services. SGAs are considered modern day treaties, and contain clauses protecting First Nations access to federal health programming provided to non self-governing First Nations, Inuit or other Aboriginal groups.

Health Canada's restrictions regarding eligibility of territorial First Nations for new First Nations on-reserve programs are based on a policy not to fund programs considered to have been transferred to the territorial governments, the use of "First Nations on reserve" to describe new program eligibility, and the interpretation of SGA clauses protecting First Nations access to general programs as only applying to general Aboriginal programs. For those programs which are subject to self-government financing, Health Canada's policy is to use population numbers which are based on status residents only. These policy decisions on northern funding are not contained in any publicly available document.

A number of issues and concerns arise from the current federal policy environment. The long term impact of Health Canada's funding policies to self-governing First Nations in the North is not known. If FNIHB restricts eligibility for new programs to only First Nations on reserve and Inuit communities, where will new program dollars come from? Will territorial governments pick up the ball for programs to self-governing First Nations? What will be the implication for self-government across the country, not just in the North, in the absence of nationally agreed upon principles and framework for federal funding of health services under self-government?

One example of the jurisdictional limbo a self-governing First Nation can be placed into concerns the need for Little Salmon Carmacks First Nation to build a piped water system which will replace the current situation where houses on settlement land use their own wells for their drinking water. The community is concerned that the land on which government housing was originally built is contaminated and is now affecting the quality of the private wells' water. The First Nation's SGA does not include federal responsibility to fund the required infrastructure. The YG's position is that as the housing is on private (settlement) land, the territorial government has no authority for the wells or the quality of its water. An application to the Federal/YG's Municipal Rural Infrastructure Fund for funding was turned down because of technical reasons concerning the type of piped system requested, and also because the First Nation did not have the capacity to meet the required one-third contribution to the project as required under this Fund.

In the current situation, it will be difficult for northern First Nations to achieve any semblance of administration and control over a full range of health services to the residents in their territories. In the NWT, including the devolution of health programs and services in SGAs would require the opening of the federal contribution agreements with

the GNWT for First Nations health programs, and disruption to existing health and social services authorities which administer territorial health and services resources, including those obtained under federal contribution agreement. There may not be a desire with some First Nations to open these agreements at this point due to lack of capacity to assume health service delivery or other competing priorities. Maintaining the status quo supports the concept of delegated authority, not concurrent jurisdictions in health services, which is the preferred option of the GNWT.

Delegated authority appears to limit the practical applications of self-government. If Health Canada continues to deal with GNWT on financing of health programs, does this render self-government ineffectual in health services? How can capacity be built when First Nations direct their energies into advocating on a case-by-case basis for program funds for which they have been deemed ineligible, and then see any funds gained being sent to the GNWT for administration?

Limited health program resources will continue to be a reality, given that First Nations in the North generally live in small communities. Incentives are needed in programs to encourage First Nations to work collaboratively together in program delivery and thereby achieve economies of scale. Territorial First Nations, who may not have their uniquely high cost of services acknowledged in funding formulas, are further penalized by inconsistent policies. A case in point is the different funding allocation used by PHAC for AHS which results in lesser resources than what provincially-located First Nations receive for AHS, and the restricted eligibility of status-only residents in the territories for self-government financing directed to delivery of health services.

Furthermore, the analysis provided in this report has shown that recent TFF transfers to the territories have tended to have larger annual increases than that seen with FNIHB expenditures to the territories, and both TFF and FNIHB increases have been greater than what the PSTA funding mechanism provides for self-governing First Nations.

Health Programs Included in NWT Health Transfer Agreement

Community Health Services

- Community disease control
- Chronic disease control
- CHR Program
- Health Education
- Medical Advice and Assistance
- Mental Health
- Nutrition
- Referral Services
- Health Liaison
- Health Information Services
- Public Health
- Treatment

Dental Services

- Dental therapy program
 - Dental health education
 - Dental preventative services including prophylaxis, topical fluorides, fissure sealants
 - Dental treatment services including diagnostic, surgical care and restorative
 - Dental service program: management and direction of diagnostic, radiography, restorations, endodontic, periodontic, surgical and prosthetic services

Environmental Health and Surveillance

- Administration
- Liaison, inspection and surveillance
- Public health engineering
- Regulatory services
- Contaminants
- Dangerous goods shipment

Hospital Services

- Inuvik
- Fort Simpson

National Native Alcohol and Drug Abuse Program

Administration

- Contracts and contributions
- Materiel management

- Property management
- Planning and control services
- Resource centre
- Electronic data processing services
- Financial services
- Indian and Inuit health careers
- Management and direction

APPENDIX 2

Modified Berger (amended) Regional Allocation Formula

A standardized approach to regional program allocations has been based on an amendment to the Modified Berger Formula (MBF). The MBF was amended in 2002-03 as a result of new ECD funding and was developed in response to regional and headquarters requirements for a principles-based formula reflecting target population, community size, and community remoteness. The allocation figures reflect a comprehensive, coherent application of the weighting formula.

1. First, a regional base allocation is applied to ensure capacity for management and support at the regional office.

2. Beyond the base amount, further funding allocations are calculated using a formula applied to target population figures from INAC data (Indian Registry) and Census data for Inuit. The target population for the Aboriginal Diabetes Initiative, the Maternal and Child Health program, and the National Aboriginal Suicide Prevention Strategy is the total population. The Aboriginal Head Start Program On Reserve program uses a target population based on children 0-6. To strive for accuracy and consistency, INAC's data has been adjusted to compensate for under-reporting.

3. Population data are weighted using a combination of the following factors: Adjustment for community size using the approved AFN values of 1.0 to 0.7, extrapolated to 1.43 to 1.0, so as to place a positive range in the formula without changing the resultant outcome. This results in a range differential of 43%.

Community size: 0-500 (1.43), 501-1000 (1.25), 1001-3000 (1.1), 3001+ (1).

- Adjustment for remoteness, with a total differential of 20%. This differential was chosen because it reflects the 20% uplift added to health workers' isolation pay.

Remoteness: remote/isolated (1.2), isolated (1.13), semi-isolated (1.067), non-isolated (1)

- The actual population weighting factor is a compound of the Community size factor and the Community remoteness factor with a range differential of 72%, as shown in the table below:

		Community Remoteness Factor			
		Non-Isolated	Semi-Isolated	Isolated	Remote / Isolated
Community Size Factor		1.00	1.07	1.13	1.20
3000+	1.00	1.00	1.07	1.13	1.20
1001-3000	1.10	1.10	1.17	1.25	1.32
501-1000	1.25	1.25	1.33	1.42	1.50
0-500	1.43	1.43	1.53	1.62	1.72

4. Thus, the formula used to determine the weighted allocation for each community is as follows:

(Target population number in a community) X (relevant remoteness factor times the relevant community size factor).

5. All community totals in a region are then added together to give the regional weighted total.

6. The **total overall regional allocation** is the sum of the regional base amount plus the regional weighted amount.